Middle Articles

GENERAL PRACTICE OBSERVED

Appointment Systems in General Practice

Do Patients Like Them, and How Do They Affect Work Load?

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There seems to me no doubt that all patients will soon expect to be able to consult their family doctor by appointment. Recent propaganda in both lay and medical press has conditioned a more sophisticated public to expect this service, and I am certain that 10 years from now appointment systems in general practice will be the rule rather than the exception. Indeed, doctors who do not offer appointments may find it difficult to attract new patients.

Much has been said for and against appointment systems, but in the end only two questions need be answered to settle the issue either way: (1) Does the patient wish to use appointments? (2) Does the doctor wish to offer them? I have now used appointments for four years. After nine months I doubted whether the patient wished this service. After two years I doubted if it was any real benefit to the doctor. Now I am certain that, properly used, appointments can be a boon to both. The purpose of this paper is to explain how my doubts were quelled.

What Patients Think

On 1 January 1962 my partners and I introduced a full appointment system during morning and evening surgeries. During the previous November and December we had used various methods to publicize the innovation in an attempt to condition our patients and ensure a smooth introduction. Notices were placed in the surgery, each family was sent an explanatory card, and every chance was taken to explain to patients what was going to happen. Despite the trouble and expense—about £50 for some 5,800 patients—we had gone to, there seemed to be an undercurrent of discontent among our patients stemming directly from appointments. After nine months this had not abated, and we wondered if the extra, not inconsiderable, effort on the part of our receptionists was worth while. It was therefore decided to prepare a questionnaire with the idea of obtaining the views of patients attending the surgery during November and December 1962.

Two polling-booths were borrowed and erected in the waiting-room. An explanatory notice was posted in each, and, to complete the illusion, an authentic ballot-box was placed on the magazine table. All patients over the age of 15 were invited to complete a questionnaire and put it in the ballot-box. They were intrigued, and the majority seemed delighted that their opinion was being sought. We had therefore no difficulty in persuading 690 of our patients to participate. There were only a few spoiled papers.

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Analysis of the results showed that there was overwhelming support for the appointments system, 595 (86.4%) being in favour of the continuation of appointments. The complete analysis and the sex difference are shown in Table I. Ca-ne and Dell (1965), in a London practice, circulated 100 of their patients to test their reaction to newly introduced appointments, and found 84% of those answering were happy with them. Dean *et al.* (1965), in Birmingham, after questioning 634 of their patients consecutively in the surgery and at visits, report a much higher proportion (98%) of contented customers.

TABLE I.—Analysis of Answers to the Question, "Would You Like the Appointments System to be Continued, Stopped, or Don't Care?"

	Female	Male	Total
Continue appointments	324 (38.3%)	271 (90.0%)	595 (86.4%)
Stop appointments ..	42 (10.8%)	17 (5.7%)	59 (8.5%)
Don't care ..	23 (5.9%)	13 (4.3%)	36 (5.1%)
Total ..	389 (100%)	301 (100%)	690 (100%)

The questionnaire had been completed in an effort to find out what type of person did not desire appointments. Unfortunately I had not taken statistical advice about its composition, and when I had extracted all the information the results were so complex that I was unable to correlate them. However, I was fortunate at this late juncture to be able to call on the help of a professional statistician, and from the maze of figures I presented to him he was able to extract the following information.

Age and Sex.—The answers suggest that males favour appointments more than females. There is no evidence that age makes any difference whether males want or do not want appointments, but it seems that young females tend to favour appointments less than their elders.

Income.—As might be expected, patients with low incomes are more likely to fall into the category of wanting appointments stopped or not caring.

Young Children.—The ages of mothers with children under 5 years of age and their decision about the appointment system were sought in an attempt to discover whether, as a group, mothers whose time was restricted by young children would find it a benefit to attend by appointment for advice either about themselves or their children. Analysis showed that having young children made no difference whether a mother wished or did not wish to have appointments, but young teenage mothers tended to favour appointments less than the group as a whole.

Likelihood of Attending Surgery or Asking for a Home Visit.—The answer to the question, "Does being able to make an appointment make you more likely to come to the surgery than before?" was answered overwhelmingly in the affirmative by 10 to 1, but

analysis showed that females were relatively less likely to do so than males. The actual numbers are shown in Table II.

TABLE II.—Sex Differentiation in Answer to the Question “Does Being Able to Make an Appointment Make You More Likely to Come to the Surgery Than Before?”

	More Likely	Less Likely
Male	296	15
Female	259	42
Total	555	57

Telephones.—Only 82 (12%) of those completing the questionnaires had telephones in their homes, and 79 of them preferred the appointment system. Of the 608 without telephones 526 wanted the appointment system to continue. As one would expect, those patients with a telephone in their homes favoured appointments more than those without.

Waiting Time.—Of those patients attending without appointment on the off-chance of being fitted in 64% said they had longer to wait than before, and 36% thought their wait shorter.

Patients’ Comments.—Over 50 patients accepted the invitation to comment on the appointment system. All but two were favourable, and the sporting way in which the questions were completed can best be summarized by the patient who, in answer to the question, wrote: “Only to say that the only people who complain about the appointment system are either too mean or can’t be bothered to ‘phone,” and added with a *cri de cœur*, “Don’t let them win.”

Some Concurrent Statistics

During the months that the questionnaires were being completed (November–December 1962) certain statistics relative to the appointment system were being kept. The total surgery attendances during the period were 2,917. Of these 2,252 (77.2%) were by appointment and 665 (22.8%) without appointment. In all, 2,424 appointments were made; 2,252 (92.9%) of these were kept and 172 (7.1%) were not. Of the 2,252 patients attending with appointment 1,164 (51.7%) made their appointment by telephone—this despite the fact that only 82 (11.9%) of those answering the questionnaires had telephones in their homes—663 (29.5%) were revisits, and 425 (18.8%) made their appointments by calling at the surgery office.

Further analysis of the 172 patients who did not keep their appointments showed that 82 (47.5%) were those who had been given revisit appointments. This was only 11% of the 745 return appointments given, and nearly half (47.5%) of these patients should have attended on Fridays and Saturdays, the normal “signing-off” days. Presumably to some of our patients the thought of a Monday morning start after a period of sick leave is too much to bear, especially when their current first or intermediate certificate entitles them to a more humane, if slightly dishonest, resumption of work in mid-week.

Most doctors (Mallett, 1960 ; Levitt, 1960 ; Carne, 1963) operating appointment systems use return appointment cards with the date and time of the next appointment written in by their receptionist. I feel the figures vindicate our decision not to burden our receptionists with this extra task, as the wastage is insufficient to justify the effort. Our patients are therefore simply told when their next appointment will be and the onus is on them to remember the details.

Benefits to the Doctor

The advocates of appointment systems rightly list the benefits which the introduction of appointments gives to the doctor, and most of these are summarized in para 94 of the Gillie Report (Central Health Services Council, 1963). However, the real benefit must be judged in terms of increased efficiency

and more economic use of the doctor’s time. In para. 45 the report states that “an appointment system helps to reduce the demand for home visits.” This had not been my experience. In a previous paper comparing statistics from various practices in the United Kingdom (Stevenson, 1964) I made two references to the introduction of appointments in our practice. Our appointment system had by then been in use for two years, and it seemed that its introduction had in fact led to an increase in the number of home visits requested and a decrease in the number of attendances at the surgery. This was slightly discomfiting, as we already knew from our own and others’ experience that in practices outside England there was a tendency for the ratio of surgery attendances to home visits to be altered in favour of the latter, with a consequent increase in work load. Was the introduction of appointments making matters worse? It certainly appeared so. However, on 1 October 1964 we joined with a neighbouring practice, and on 30 September 1965 I analysed our first year’s work. This showed a very different picture. What then made the difference?

Our new practice was one of four principals where previously there had been three. We had just built a new centrally heated surgery, consisting of two consulting-rooms, with a waiting-room and a central records office connected to each consulting-room by two hatches. In order to use the premises most economically we decided that we should attempt “all-day” consulting and aim at finishing at six in the evening. We had been suspicious that our appointment system had been only partially successful in the past because of the limited consulting-time available to patients. This had been one hour per week for every 200 patients. We therefore decided to increase our consulting-times by 25%—that is, one and a quarter hours per week for every 200 patients. We estimated our new practice size at 9,200, which meant that 58 hours were to be allowed each week for consulting. Working from this, we made out the duty roster (Table III).

TABLE III.—Rotating Four-week Duty Roster for Four Doctors

Consultation Times	Extra Duties	Mon.	Tues.	Thurs.	Fri.				
11.15 a.m.- 12.45 p.m. } 4-6 p.m. }	On call for emergencies and visit maternity hospital	A	C	B	D				
11.15 a.m.- 12.45 p.m. } 4-6 p.m. }	—	B	D	A	C				
9-10.30 a.m. } 2-4 p.m. }	—	C	B	D	A				
9-10.30 a.m.	—	D	A	C	B				
		Wednesday				Saturday			
		Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
9-11 a.m. ..	On call. Visit mat. hosp. Children's clinic (Wed.)	A	C	D	B	D	B	A	C
9-11 a.m. ..	Maternity (Wed.) clinic	D	B	A	C	A	C	D	B
—	Dental anaesthetics (Wed.)	C	D	B	A	B	A	C	D
—	Day off (Sat.)	B	A	C	D	C	D	B	A

Each day after the first consulting session 45 minutes were set aside for all four doctors to meet in the surgery over coffee. We considered this daily “get together” of such importance that we now feel the period is too short. During the break we discuss all manner of things relative to our joint work, and in doing so subconsciously exert a continuing vigilance over each other’s thoughts and actions. This is the very essence of partnership practice. Everyone benefits—especially the patient. Partnerships which exist without this interchange of thought and criticism are partnerships of convenience only, and are little likely to encourage the professional development of the doctors involved.

To cope with the extra office work, and to give 8.30 a.m. to 7 p.m. receptionist cover, we engaged an extra full-time secretary/receptionist, making our office staff two full-time and one part-time secretary/receptionists; these and a daily cleaner completed our new staff. We also approached our two district nurses, who, with their supervisor's permission, agreed to help us with our antenatal clinic, and one or both attend this weekly session with whichever doctor is conducting the clinic. This loose attachment to us has fostered a much closer liaison between the nurses and ourselves, and, although I am sure that they themselves benefit by being more a part of the team than before, the benefit to us is much greater.

Effect of Improved Organization on Work Load

The work undertaken by the new practice was analysed after one year and compared with the last complete year of the old practice. The results are summarized in Table IV.

TABLE IV.—Summary of Practice Size and Work Done in the Year 1963 and the Year October 1964 to September 1965 with the Percentage Increase or Decrease Between the Two Periods

	Practice Size	New Calls	Revisits	Total Home Visits	Surgery Attendances	Total Consultations	Consultation Rate per Patient
Jan.-Dec., 1963	6,072	5,980	10,259	16,239	18,589	34,828	5.7
Oct. 1964–Sept. 1965	9,252	7,644	7,447	15,091	29,896	44,987	4.9
Increase or decrease (%)	+52.4	+27.5	–27.4	–7	+60.8	+29.2	–10.5

Practice Size.—The number of patients rose from 6,072 to 9,252, an increase of 52.4%.

New Calls.—These increased by 27.5%, from 5,980 to 7,644; but the new call rate per 1,000 patients fell from 984 to 827—the lowest figure we had recorded for some years. Late calls—that is, those received after 10.30 a.m.—were 22.5% of the total. (Our late-call rate has remained virtually unaltered since this was first recorded in 1961, and each year it has been around the 20% mark. Nothing we have been able to do seems to reduce this most irritating and often unnecessary habit of the late request for a home visit.)

Revisits.—Despite the increase in the size of the practice there was an actual reduction of 27.4% in revisits, from 10,259 to 7,447. This was due to three factors—namely, a continuation of our policy of more critical assessment for the need to revisit, more time was being spent in the surgery with consultations, and the increase in the number of patients at risk per doctor.

Total Home Visits.—Owing to the comparatively small increase in the demand for new calls and the drop in revisits our total home visits fell from 16,239 to 15,091—that is, by 7%—this despite the increase in practice size of 52.4%.

Surgery Attendances.—This was the only aspect of the year's work which showed a percentage increase greater than the increase in practice size. During the year surgery attendances increased by 60.8%, from 18,589 to 29,896. This was most gratifying, and seemed to vindicate our decision to persevere with our appointment system.

Ratio of Surgery Attendances to Home Visits.—The ratio of two surgery attendances to one home visit showed a greater bias towards surgery attendance than we had previously recorded but compares unfavourably with the 4-to-1 ratio experienced by many practitioners in England (Stevenson, 1964). I feel this is due in the main to three factors—the greater availability of the doctor for consultation throughout the day, the saving of patients' time which appointments afford, and the congenial yet efficient atmosphere of our new premises.

Total Consultations.—There was a total increase of 29.2% in patient-doctor contacts at the surgery and in the home.

The number increased from 34,828 to 44,987, but this shows a proportionate decrease in work load when equated with the increase in practice size.

Consultation Rate per Patient.—This was 4.9 for the year—the lowest ever recorded since our records started in 1957. Though this represents a more reasonable work load, it is still high when compared with most practices in England (Stevenson, 1964).

From 1957 to 1963 our practice was manned by three doctors, and from October 1964 to September 1965 by four. The attendances per patient during these periods are shown in Table V.

TABLE V.—Average Work Done by Three Doctors 1957–63 and by Four Doctors October 1964 to September 1965

Year	No. of Patients per Doctor	Home Visits per Doctor			Surgery Attendances per Patient per Doctor	Total Consultations per Doctor
		New Visits	Revisits	Total		
		Three Doctors				
1957	1,719	1,556	4,281	5,837	6,408	12,245
1958	1,748	1,394	4,331	5,725	6,080	11,805
1959	1,806	1,561	4,660	6,221	6,293	12,514
1960	1,862	1,665	4,365	6,030	6,463	12,493
1961	1,909	1,709	3,995	5,704	6,363	12,067
1962	1,958	1,867	4,061	5,928	6,119	12,047
1963	2,024	1,993	3,420	5,413	6,196	11,609
		Four Doctors				
Oct. 1964– Sept. 1965	2,317	1,911	1,862	3,773	7,474	11,247

Two items remain fairly constant throughout the period—the new visits demanded by the patient and the total items of service dispensed by the doctor. The number of new visits remains largely under the control of the patient, as to a less extent do surgery attendances; therefore the only way that a doctor can personally affect his work load is by his own particular attitude and policy to revisiting. In our case the number of revisits has fallen over the period by nearly 70%, while surgery attendances have fallen by only 15%. If the pattern were consistent one would have expected the latter to have fallen more drastically. It therefore follows that the fall in revisits has been due to no other factor than our pre-determined policy to revisit less often.

The total number of patient-contacts which each doctor made throughout the period shows a remarkable stability for each year despite the variability in the number of patients at risk. It would seem reasonable to suggest that, whether consciously or not, each doctor is capable of spreading a very exact amount of cheese, in the form of medical attention, over a variable number of biscuits, and that the thickness or thinness of the cheese is dependent on the number of biscuits. One can only presume what the optimum amount of cheese per biscuit should be.

Cost of Improved Practice Organization to the Doctor

Despite an increase in practice size equivalent to 13% per doctor, each doctor's net income before deduction of personal tax and car expenses increased by only 4% during the year ending September 1965.

Discussion

It would seem that appointment systems once introduced become readily acceptable to both patient and doctor. According to the Gillie report doctors seldom abandon them, and I and others have found that most patients want them to continue. After having appointments for two years we in our practice were almost on the point of abandoning them, as our statistics had indicated that, with an increase in the number of home visits demanded and a reduction in the number

of surgery attendances, appointments seemed to be adding to our already heavy work load. However, by increasing the size of our group, improving the general organization of work, employing extra ancillary staff, having the cooperation of the district nurses, and, perhaps most important, becoming more readily available for consultation throughout the day, we have apparently reversed this trend, and find that now, after our first year, surgery attendances far outnumber home visits. There has also been an overall reduction in work load, which, though still remaining above average, is more in keeping with work loads reported from practices in England.

With the present reduction in medical manpower available this more economic use of the doctors' time and energy is most important, and, despite the considerable increase in the running costs borne by the partners, it would seem that our decision to group, to continue with appointments, and to improve our organization has been vindicated in terms of a better deal for both patient and doctor. Were the benefits all ours we would not object to the increased cost to ourselves, but we would like to think that our patients too have benefited by our endeavours. For how much longer must the quality of supervision be dependent on the doctor's conscience, to the financial detriment of himself and his family?

To organize such a system of group practice as I have described requires a practice large enough to support a minimum of four doctors, preferably working from central consulting premises. It also requires that the individual patient must consider himself as being medically supervised by the group as a whole and not by an individual member of it. This leaves one question to be answered: Does the patient suffer? I do not believe he does, but I am certain that his idea of the constantly available personal family doctor is rapidly vanishing, and I am equally certain that many regret this. But we alone must make the decision on what type of medical care our patients receive. They cannot possibly judge for themselves what is medically best for them. The commonly held lay belief that the best doctors attract the largest number of patients is proof of this. I firmly believe that the development of general practice in this country has suffered immeasurably from the profession's reluctance to burn the effigy of the frock-coated personal medical attendant. He is the anachronism of present-day general medical practice.

The question is often asked, How much work can any family doctor be expected to undertake? In the light of my findings it would seem that in 1957 we were fully extended workwise. Throughout the whole period reviewed we continue to exert virtually the same effort each year, but by various improvements in organization, at our personal expense, we have been able to spread the effort over a progressively larger number of patients, and, by making our exertions medically more effective, I believe we have improved the quality of the service we give. But what will happen as the partners get older and find they cannot keep up the same pressure of work? What will happen if the list grows to a point when it becomes unmanageable and it is difficult or even impossible to get another partner? What will happen when the point is reached when we just cannot afford any further improvements or the extra ancillary staff necessary to combat the waning productivity of the doctor and the increasing number of patients?

One other question worth considering is what should be the maximum size of list per doctor? In view of the wide regional variation in work load it would be impractical to suggest a figure which would apply to all areas. It might, however, be expedient to take 12,000 patient/doctor contacts in urban areas as the absolute maximum which any individual doctor can be

expected to deal with in any year. If then in Ayrshire the contact rate per patient per annum is 5, made up of 0.8 new visits, 0.8 revisits, and 3.4 surgery attendances, then the practice size there should be limited to a maximum of 2,400 ($12,000 \div 5$) per doctor. If, on the other hand, the rate in, say, Manchester is 4 (0.6, 0.6, and 2.8 respectively), then with the same doctor effort 3,000 patients could be supervised. Assessment of the work load in rural areas would be more difficult, but I am sure there is a similar pattern of differing regional demands. Much more information is required before determining the maximum and optimum size of practices; but I am certain that the problem must be tackled on a regional basis, and I welcome the suggestion that regional health boards should be established.

Whatever happens in the future we must not be prevented by our patients' complacency with the *status quo* from striving to improve the service we can offer. We, not our patients, know what a good medical service is. It is our responsibility to tell them and let them decide whether they can afford to ignore the defects in the present one.

Summary

Our patients' favourable reaction to the introduction of an appointment system is discussed. The benefit of appointments to the doctors became apparent only when they made themselves available for surgery consultation throughout the day. The effect of this and of other improvements in practice organization has led to a reduction in work load.

It is suggested that the minimum number of doctors who can provide such a service is four, and a plea is made that, where possible, doctors should group together to their own and their patients' mutual benefit. The patient must, on his part, learn to regard himself as being medically supervised by the group as a whole and not by a particular member of it.

It would appear that the general practitioner is at present working at full pressure, and is not in a position to meet any further demands. Only by delegating to ancillary helpers some of the work which he is already doing can he undertake new and perhaps more important commitments. The ancillary staff must either be provided or the doctor be put in a financial position where he can afford it.

It is suggested that the medical needs of the community vary from region to region, and that the decentralization of administration, with the establishment of regional health boards, should be the next step in the evolution of the Health Service.

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